Texas Department of
Family and Protective Services

Form P-201-2037
Revised July 2021

# REFERRAL FOR PLACEMENT IN A HHSC FUNDED RTC

**Purpose:** Use this form to refer children who are not in DFPS Conservatorship to be considered for placement in a HHSC-funded Residential Treatment Center (RTC).

**Directions:** To complete this form please provide all information requested in the boxes below. This will assist in making a determination for an RTC. For questions or more information regarding this form please send an email to the DFPS State Office Mental Health Mailbox: SOMH@dfps.texas.gov

| CHILD'S INFORMATION | | | | | |
|---|---|---|---|---|---|
| Date of Referral: | Region: | County: | Date Referral is Received in State Office:<br>DFPS/HHSC Consultation Date: | | |
| Child's Name: | | IMPACT Person ID: | DOB: | Medicaid Number: | SSN: |
| Gender:<br>☐ Male ☐ Female | | | US Citizen:<br>☐ Yes ☐ No | | |

| REFERRAL |
|---|
| Briefly describe circumstances for this referral: |
| Is RTC placement desired in a certain area of the state (e.g., in close proximity to parents/guardian)? :<br>☐ Yes ☐ No; If so in what county: |
| Is the family at risk of relinquishing custody to DFPS only to access mental health services for the child? :<br>☐ Yes ☐ No |
| Is the family eligible for services under 6954 Post Adoption Substitute Care Services? :<br>☐ Yes ☐ No;<br><br>If Yes, have all Post Adoption Substitute-Care Services been exhausted? :<br>☐ Yes ☐ No |
| Will the disposition of *Ruled-Out* be given for all allegations against the caregiver or caregivers seeking RTC treatment for the youth? :<br>☐ Yes ☐ No |

## CHILD'S CIRCUMSTANCES

History of Mental Health Diagnosis:

Other conditions:

☐ Yes ☐ No;
Describe:

Is the youth's IQ 70 or above? :

☐ Yes ☐ No

Is testing available? :

☐ Yes ☐ No; if yes give dates:

☐ Psychological Evaluation:

☐ School Testing:

☐ Other:

Previous and current treatment therapies:

☐ No ☐ Yes ;

Describe:

List names of Local Mental Health Authorities that have been involved with this child:

Does the child have a history of hospitalizations:

☐ No ☐ Yes;

If yes, give names and dates:

Where is the child currently residing? :

- ☐ Parents or person legally responsible for the child
- ☐ Relative or caregiver not legally responsible for the child
- ☐ Emergency Shelter. Name:
- ☐ Hospital Emergency Room Name:
- ☐ Psychiatric Hospital Name:

| Address of current residence: | Phone number of current residence: | County of current residence: |
|---|---|---|
| | | |

| PARENT, GUARDIAN, OR CAREGIVER CONTACT INFORMATION | |
|---|---|
| Name of parent, guardian, or caregiver: | Relationship: (parent, guardian, or caregiver): |
| Phone number of parent, guardian, or caregiver: | Address of parent, guardian, or caregiver: |

| CPS INFORMATION | |
|---|---|
| Name of CPS Worker: | Phone number and email address of CPS worker: |
| Name of Supervisor: | Phone number and email address of Supervisor: |

| FOR HHSC USE ONLY | |
|---|---|
| Refer to: | Date of Referral: |
| LOC: | Date of LOC Determination: |
| Placed with: | Date of RTC Placement: |
| RTC Contact Information: | |
| Address: | |
| Phone/Email: | |

| PRIVACY STATEMENT |
|---|
| DFPS values your privacy. For more information, read our Privacy and Security Policy. |